



OSCEOLA COUNTY HEALTH DEPARTMENT PATIENT DATA FORM

Ron Desantis, Governor

SECTION 1

Name: _____ SSN: _____ Date of Birth: _____

Address: _____ Gender: ☐ M ☐ F

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Race: ☐ Asian ☐ Black ☐ Native American ☐ White ☐ Other _____ Ethnicity (Hispanic): ☐ Y ☐ N

Have you ever received care at the Osceola County Health Department? ☐ Y ☐ N

Have you ever been diagnosed or had any of the following conditions?

☐ Blood Disorder ☐ Arthritis ☐ Cancer
☐ Hypertension ☐ Diabetes ☐ Heart Disease
☐ Chronic Back Pain ☐ Migraines ☐ Other _____

Guardian Information (if under 18 years old):

Legal Guardian: ☐ Y ☐ N

Name: _____ Relationship: _____

Address: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Emergency Contact (Nearest relative not living with you):

Name: _____ Relationship: _____

Address: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

SECTION 2

Are you currently covered by Medicaid? ☐ Y ☐ N If yes, Medicaid/Card Number: _____

Do you have: ☐ Medicaid ☐ Healthsease ☐ Amerigroup ☐ Staywell ☐ United ☐ KidCare

Are you currently covered by Medicare? ☐ Y ☐ N If yes, Card Number: _____

Are you currently covered by any other insurance? ☐ Y ☐ N If yes, Insurance Name: _____

Policy #: _____ Group #: _____ Deductible Amount: _____

Insurance Co. Address: _____

SECTION 3

Total Number of Persons in Household (include unborn): _____

Total Earned Income for the Household (one month): _____
Before Deductions - (Wages, Salaries and Tips)

Total Unearned Income for the Household (one month): _____
(AFDC, VA, SSI, SSA, Contributions, Unemployment, Worker's Comp., Child Support)

Name of Business Where Employed: (1) _____ (2) _____

Phone Numbers of Employer: _____

SIGNATURE OF CLIENT or RESPONSIBLE PARTY _____

DATE _____

EMPLOYEE SIGNATURE _____

DATE _____